MEDICAID RESOLUTION INQUIRY

MAIL TO:
EDS PROVIDER SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: ☐ Claim Inquiry ☐ Medicare Override ☐Time Limit Override ☐Third Party Override

NOTE: PLEASE USE THIS FORM FOR **OVERRIDES AND INQUIRIES ONLY.**
CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED.
ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.

Provider Number: _____

Provider Name and Address:_____

_____

Patient's Name: _____Recipient ID: _____

Date of Service: From: / / to / / Claim Number: _____

Billed Amount: _____Paid Amount:_____RA Date:_____

Please Specify Reason for Inquiry Request:

Signature of Sender: Date: Phone #:

TO BE USED BY EDS ONLY

Remarks: